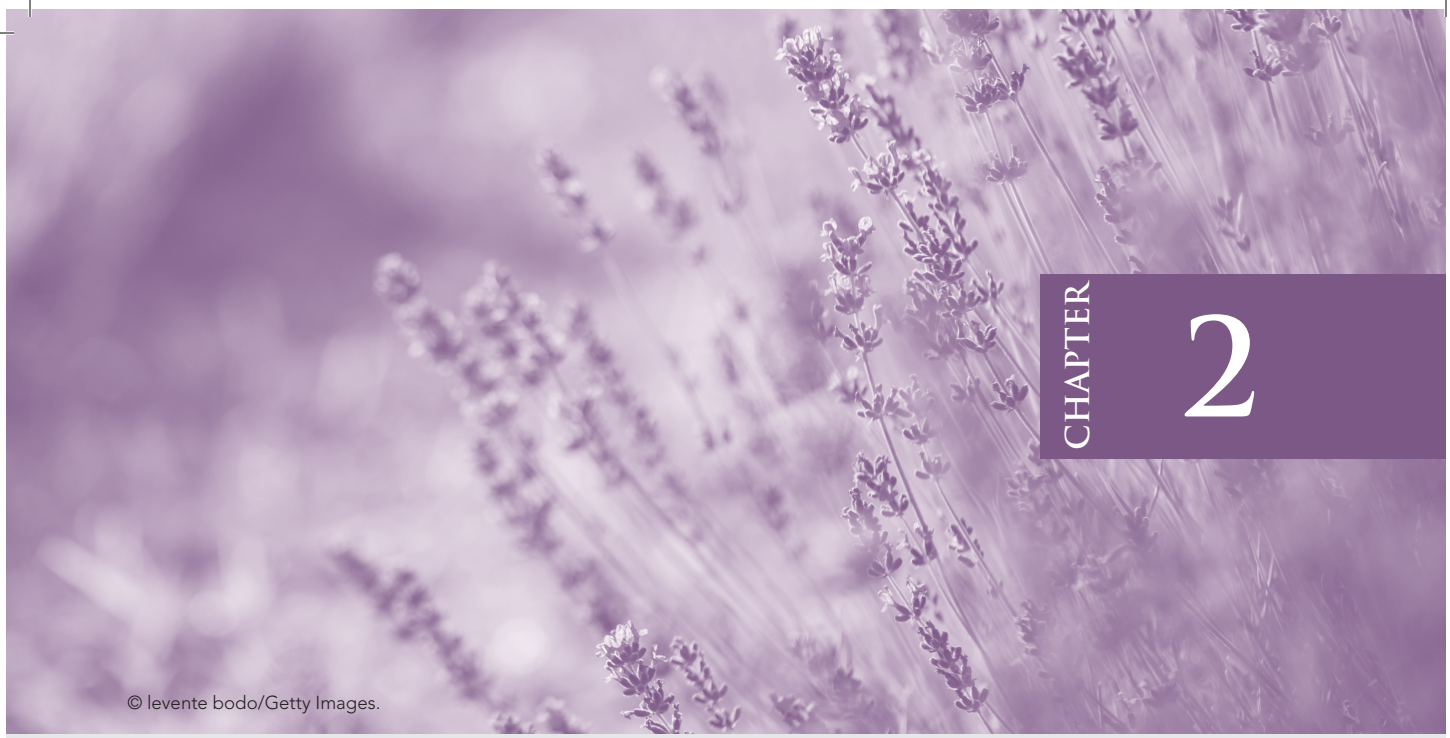

CHAPTER 2



# ETHICS, CONFIDENTIALITY, AND PROFESSIONAL RESPONSIBILITY

## OBJECTIVES



**At the end of this chapter, students will be able to:**

1. Describe the importance of ethical decision making in substance use disorder (SUD) counseling.
2. Describe the need to use supervision in any ethical issue that they see arise.
3. Describe the value and purpose of both the federal confidentiality regulations and Health Insurance Portability and Accountability Act (HIPAA).
4. Explain to a client the meaning of informed consent.
5. List at least four exceptions to confidentiality when disclosure can be given.
6. List two conditions in which there is a duty to warn.
7. Describe at least six principles that may be taken into consideration when an ethical dilemma arises in counseling.
8. Describe at least three ways to become involved in your own professional growth.
9. Provide at least three examples of how clients and counselors can cross boundaries and how these create ethical and legal problems.
10. Identify three examples of unethical representation of services.

# INTRODUCTION

Ethical principles define and govern the right, good, and moral behaviors that are expected in proper professional relationships. Ethical standards are developed and maintained by associations and credentialing bodies of real estate brokers, lawyers, helping professionals, and others. They are motivated by a desire to protect clients, to avoid governmental interference and malpractice suits, and to develop public confidence in general and client confidence in particular.[a]

There is a compelling necessity for ethical standards in the counseling relationship. Counselors hold a great deal of power over clients; mechanisms are necessary to ensure that this power is not abused. The overall objectives of counseling ethics are to maintain client welfare as foremost, to do no harm (physical, emotional, or financial), and to maintain standards of responsibility, integrity, and accountability.

Although confidentiality is the area most regulated by legal statutes, not all critical areas of ethics are formulated into legal statutes. Professional conduct can be legal but not ethical.

Many SUD counselors, like their clients, participate in a SUD recovery milieu. This and other relatively informal aspects of the SUD field blur boundaries and roles, creating possibilities for ethically compromising situations.

Ethical standards supersede all other considerations. All counseling actions and decisions must be considered from the standpoint of and be governed by these standards.

In the preparation of SUD counselors, specialized ethics training is the area most often cited as inadequate. Furthermore, internal agency discussion of ethical issues is sometimes muted out of shame, fear, confusion, or expediency; this can be summed up by the term *institutional denial* (Myers, 1990; White & Popovits, 2004, p. i, 1). Counselors must bear in mind that institutional systems of the agency and broader society generate a climate and a range of options that bear on individual ethical choice.

## ACTIVITY 2.1 Easier said than done

*In a large or a small group, each person states one principle or guideline by which he or she lives (in the broadest sense, an ethics statement). Typical responses are "I never lie," "I never kill or hurt someone," and "Honesty is the most important to me."*

**Discuss:** Consider the following questions and discuss your answers with each other.

- ☐ Do you subscribe to the statement "Thou shall not kill?" Have you killed an animal or put a pet to sleep?
- ☐ Do you believe it is wrong to steal? In what situation is it alright to do so, if any?
- ☐ Have you ever covered up for a friend's mistakes or lateness at work by lying to a supervisor?
- ☐ Have you ever been aware of mistreatment or neglect of a child but did not communicate this information to authorities, nor confronted the perpetrator?
- ☐ Have you taken an office item home from work or photocopied a personal item at the office?
- ☐ What other small or large actions reflect your ethics?

**Process:** Can you identify connections among the ethics statements you made, your values and morality (preferences and judgments), group customs (traditional ways of doing things), and laws (standards set by legislative authority)? Are ethical choices absolute? For example, are there circumstances in which it would be permissible to plan to kill someone?

[a]We are deeply indebted to William White and Renee Popovitz, whose landmark book, *Critical Incidents* (White & Popovits, 2004), has brilliantly outlined the areas of ethics training for SUD counselors. Their "critical incident" method sets a standard for ethics training and has significantly influenced the format of this chapter.

The mandatory orientation of a client that takes place during the intake process includes information about the agency's confidentiality guidelines and practices. The client receives a summary of regulations concerning confidentiality and signs the summary to attest that he or she has understood. The client and the agency each keep a copy of the signed form. At the same time, for the purposes of case management, the counselor may request that the client sign a Consent for Release of Information form that stipulates exactly what client information can be released and to whom. When information is divulged legally to a third party, that third party cannot release it to anyone. As of March 2017, a client may allow disclosure to "my current and future treatment providers." The two most common uses of the consent form are as follows:

- To allow continuity of care when different facilities are involved in the client's treatment (e.g., detoxification and rehabilitation units)
- To report a client's compliance to a referring agency (e.g., EAP administrator, parole officer)

## GRAY AREAS

Activity 2.1 shows the impossibility of devising precise rules for human behavior. In ethical counseling, *knowledge* of guidelines must be supplemented by the *skills* of interpreting complex situations and of *applying* ethical standards to them. Also pertinent to ethical counseling are developing and maintaining awareness of the counselor's personal needs and feelings, evaluating how they influence the counseling relationship, and ensuring that clients' interests are held foremost. Often, counseling situations occur in which there are competing ethical and/or other obligations. Moral dilemmas arise out of conflicts between two or more beliefs, values, laws, or standards. In resolving such dilemmas, it is useful to establish a hierarchy of ethical standards, that is, a list of ethical concerns rated according to which predominate or take precedence over others. Lowenberg and Dolgoff (1988) present such a hierarchy of ethical standards:

1. Protecting human life
2. Fostering independence and freedom
3. Fostering equality
4. Promoting a better quality of life
5. Protecting the right to privacy
6. Truthfulness
7. Abiding by rules and requirements

Standards vary in their attempts to be specific. Some are brief and sketchy; others go into great detail to cover every eventuality.

## SUPERVISION AND CONSULTATION

Consultation with supervisors or other professionals is necessary to ensure a continuing ethical relationship between counselors and their clients, especially in situations where there appears to be a conflict among ethical standards or between ethical and other considerations. Seeking appropriate consultation is considered an ethical necessity in most helping professions (NASW, 1999, 2.05). Not to seek advice from others can be unrealistic, inflexible, unwise, and even unethical. One may need to speak to experienced peers or clinical supervisors or to call on the expertise of those trained in other helping professions, such as psychiatry or neurology. Consultation should come sooner rather than later.

Consultation with supervisors about ethical considerations, when carefully documented in clients' records, helps protect both the counselor and the agency in litigation and governmental audit. *Failure to consult* is a subcategory of negligence in malpractice law (Hogan, 1978).

Guidelines for supervision of counselors in private practice vary considerably among the helping professions. Failure to provide adequate supervision is unethical and grounds for action under malpractice law (Hogan, 1978). *Supervision* has both administrative and clinical dimensions. Although it would be ideal to separate these roles so that there is a space where counselors can feel safe

expressing their self-doubts, problems, and errors; in the real world, the immediate supervisor often serves both administrative and clinical functions. This reality challenges the supervisor's own ethics when he or she must weigh the factors of a situation that puts clinical and administrative concerns in conflict. Probably, the most typical example of this conflict is that a client needs more personal attention and a longer stay in treatment, but the supervisor is charged with encouraging counselors to see as many clients as possible during a workday and to discharge them from treatment as quickly as possible.

Ethical supervision must be adequate, nonvindictive, and facilitate growth. The supervisory process should be based, at least in part, on routine objective criteria for evaluation, a structure that helps to avoid, but cannot prevent all, personal or subjective situations. Some SUD treatment agencies hire graduates of the program as counselors. Objective evaluation may be compromised if supervision is assigned to a former primary counselor of this individual. The supervisor should share evaluative data with supervisees on a regular basis, and supervisees need an opportunity to respond (NASW, 1999, 3.01, 3.03).

## CASE IN POINT

### An Unacceptable Excuse and a Misuse of Consultation

A clinician treating a very hyperactive preadolescent failed to diagnose that the client had attention-deficit hyperactivity disorder. She felt increasingly angry and frustrated, which compromised her ability to counsel the child. Instead of withdrawing from the case, she ended up in a physical struggle with the child, in which she administered a spank. When confronted by the parents, the clinician claimed to have had a post hoc "consultation" with an eminent child psychologist that supposedly justified the events that had transpired. It is not clear if the clinician provided an accurate account either to her consultant or to the parents.

There is a continuum in supervisory relationships: At one extreme, a clinical or administrative supervisor may micromanage the counselor and perhaps employ a punitive or parental style, preventing professional growth and self-sufficiency as well as generating tension between counselor and supervisor; and at the other extreme of the continuum, there may be a detached and/or lazy supervisory relationship, and/or the supervisor may take on a "buddy" role. The zone of effective supervision is the halfway point between the two.

## BOUNDARIES

SUD treatment is unique because a large proportion of staff is also in recovery from that which they are treating. Boundaries are an issue in all realms of counseling but come to the forefront more often and more easily in the SUD field, because recovering counselors and clients share similar histories, issues, and even membership in self-help fellowships. Such an issue cuts to the core of the professional counselor–client relationship. With the best will in the world, failure to delineate and differentiate these identities destroys the professional identity and role, and leads to any of a number of ethical compromises, violations, and manipulations. Regardless of the setting, but especially in SUD counseling, counselors are counselors—not bowling buddies or business associates. Counselors cannot paint clients' houses, treat them to lunch, provide lodging, lend them money, or borrow money from them (not even $1 for a cup of coffee). As a real example, a counselor was charged by a state certification board for SUD counselors for taking a client to his home, even though there was no inappropriate behavior during this time.

## SEXUAL RELATIONS

Therapy sessions are emotionally intimate, and this intimacy can be confused with romantic or sexual feelings. We discuss this in greater detail in Chapter 3 when we consider transference, a clinical

treatment issue. Counselors must be vigilant that appropriate boundaries are not crossed. In all professional codes of ethics, sexual relations with clients is strictly forbidden. This almost always includes former clients, and even may extend to relatives of clients. Moreover, a majority of states have laws forbidding sexual contact, and in most of those, it is a felony offense (NASW, 2013). Sex with clients is an abuse of power and trust, is harmful to clients, and is a frequent subject of malpractice lawsuits. Not only is sexual relations the subject of ethical and legal codes, but so is sexual touching, fondling, and kissing. Supervisors and the agency itself may be subject to penalties (ACA, 2014, A5b,c; NADAAC, 2016 1-23, 1-42).

## NEW ROLES

With the development of new recovery roles, such as the recovery coach, recovery mentor, or peer recovery advocate (terminology varies state by state), one can confuse these paraprofessional roles with that of the sponsor in a 12-step fellowship. Ethics training is almost always part of the credentialing curriculum established by the state or other credentialing agency. In cases in which police departments recruit civilian "angels" in the PAARI (Police Assisted Addiction and Recovery Initiative) or Gloucester Initiative, ethical training may be minimal. Ethical breaches involving "angels" or peer recovery advocates may include using them as "headhunters" for particular treatment facilities. They also may not be familiar with patient placement criteria and bring clients to an incorrect level of care. Worse, they may ignore placement criteria in order to inflate their success rate or get a commission from a treatment agency (ADAW, 2016; White, 2006).

Although there are some very strict standards about personal boundaries, there are also gray areas. For example, how much self-disclosure by counselors is appropriate or ethical? Is hugging, which is permitted and encouraged by many support and self-help groups, appropriate or ethical? Touching a client with the appearance, implication, or suggestion of sexuality is clearly an ethical violation, but is it always wrong to hug or put an arm around a client? Obviously, this is an area where ethical standards vary (Pope & Vetter, 1992, 401; Rhodes, 1992, 43–44).

## LEGAL ISSUES

### Confidentiality

A major legal and ethical obligation of SUD counselors is to maintain privacy regarding information revealed by clients, whether it be in written records (charts, memos, notes, messages, email, and electronic files) or verbal communications. The counseling relationship, like that of lawyer and client, or cleric and penitent, is *privileged*, legally covered with a code of silence. Federal laws protect clients' identities and records. The latest Federal Confidentiality of Patient Records Regulations, CFR 42 Part 2, of the Code of Federal Regulations, went into effect on March 2017 (HHS, 2017). They apply to "Part 2" programs—that is, true SUD treatment programs. State regulations vary, and in recent years, the law of privilege has been strengthened in some states but threatened or eroded in others. In situations in which there is a conflict between these statutes, federal guidelines prevail. Every counselor must be informed as to how specific state regulations interpret federal statutes (see "Professional Growth" later in this chapter).

The Alcoholics Anonymous and Narcotics Anonymous (AA/NA) tradition of confidentiality for their 12-step groups is not a legal statute.

However, in general, the courts recognize AA/NA as religions, and therefore, certain communications within the fellowships need not be admitted as evidence in court cases, as they are covered under clergy privilege, a form of evidentiary privilege. In general, the conversations between a sponsor in AA and the sponsored party would be private and privileged. However, conversations between AA members on the street or in their homes would not necessarily be covered. The courts have vacillated on interpreting such situations, especially

in the case of Cox vs. Miller ( Diaconis, 2014), also known as the Paul Cox case , in which Cox, in a blackout, killed two people, but later, as a member of AA, remembered it and shared it with others in the fellowship.

In addition to the CFR 42 rules, there is the complex Health Insurance Portability and Accountability Act of 1996—the HIPAA regulations. HIPAA parallels CFR 42 Part 2 to a great extent. It applies to "covered entities," which are health plans and healthcare providers who transmit health information in electronic/computer-based forms, for submission of claims, coordination of benefits, referral certification, and authorization. According to HIPAA regulations, in a pharmacy, clients have to stand behind a line so they cannot see who is signing for their medications ahead of them; in a clinic, the sign-in sheet is kept out of plain view; computer workstations at agencies log off automatically if the user is away for a long time; passwords change at an alarming rate; and workstations are placed in discrete locations. All staff members of a "covered entity" are expected to be trained in the implementation of HIPAA so as to properly process "Protected Health Information" (PHI). Agencies have found the implementation of HIPAA bothersome; although they do acknowledge that HIPAA has many valuable safeguards for clients in this electronic age. However, it is not enough that all these safeguards are practiced; program participants have to be made aware of these safeguards. Agencies subject to both the old federal (42 CFR) and the new HIPAA regulations can combine them into a single notice. There are some new patient rights, such as the right to request restrictions in the uses and disclosures of PHI, and the right to access, amend, and receive an accounting of disclosure of PHI. Most large agencies compile their own manual of regulations and forms and designate a privacy officer to oversee its administration; it is important to be familiar with this manual.

The governing principle is that all information communicated by clients in programs or individual treatment is privileged and confidential. This principle is based not only on the right to privacy but also on the likelihood that clients will accept and succeed in treatment if they can be confident that information is protected. There are a few, clear exceptional circumstances in which information revealed by clients can be communicated to others.

## Duty to Warn

When information reveals a clear danger to the client or others, such as suicidal or homicidal intent, a professional obligation called the *duty to warn*, in which you notify medical personnel or police, supersedes confidentiality. In addition, in most states, it is a legal obligation to inform the police if any crime is threatened or committed against an agency's staff. Penalties for failure to warn vary from state to state. Individuals harmed by such failure often seek compensation by instituting lawsuits.

### CASE IN POINT

#### Duty to Warn: The Landmark Case

On October 27, 1969, Prosenjit Poddar killed Tatiana Tarasoff. Tatiana's father, Vitaly Tarasoff, sued, alleging that 2 months earlier, Poddar had confided his intention to kill Tatiana to psychologist Dr. Lawrence Moore of the Cowell Memorial Hospital at the University of California at Berkeley. On Moore's request, the campus police briefly detained Poddar, but they released him when they concluded that he was rational. They further claimed that Dr. Harvey Powelson, Moore's superior, directed that no further action be taken to detain Poddar. Thus, the victim and her parents were not warned of her peril.

The defendants included Dr. Moore, the psychologist who examined Poddar and decided that Poddar should be committed; Dr. Gold and Dr. Yandell, psychiatrists at Cowell Memorial Hospital who concurred in Moore's decision; and Dr. Powelson, chief of the department of psychiatry, who countermanded Moore's decision and directed that the staff take no action to confine Poddar.

Most counselors have heard of the famous Tarasoff case—*Tarasoff v. Regents of the University*

*of California* 551 P.2d 334 (1976)—but few are aware that the supervisor as well as the treating psychologists were held liable in this landmark case. The supervisor has the same duty to protect a third party (Tatiana) as does the supervisee.

A later landmark case, *Jablonski v. United States* (1983, Ninth Circuit, U.S. Court of Appeals), found a therapist and the therapist's supervisor negligent for failing to accurately predict a homicide based on the psychological profile of their client.

Legal criteria for predicting dangerousness usually include the following:

- Past violent behavior
- Specific and/or detailed threats
- Repeated threats
- Violent thoughts
- History of irrational and unpredictable behavior

Supervisors must ensure that their supervisees understand and effectively implement mandates on warning a third party and they must carefully document that they did so as well as document any warnings that did take place.

### Duty to Protect an Individual at Risk of Suicide

A counselor would be liable if he or she:

- Failed to assess and diagnose the client.
- "Abandoned" the client by abruptly terminating the client, failed to respond in an emergency, or did not have backup coverage when he or she was unavailable.
- Assisted with the suicide, say, by encouraging the misuse of medications.
- Contributed to a suicide through inaction.

A supervisor would be liable if she or he failed to direct the counselor properly in this situation (Falvey & Bray, 2001).

### Duty to Report

Initial reports of child abuse and neglect are stipulated by the federal Child Abuse Prevention and Treatment Act of 1974, which denies federal grants to states that do not comply with reporting standards. The Duty to Report to child protective agencies in a region overrides or supersedes confidentiality rights.

The duties to warn and to report child abuse do not throw open agency files; they merely mandate the provision of specific information to the appropriate authorities. State regulations define what constitutes child abuse. Anyone who works with children is a *mandated reporter* of abuse, even abuse that the professional observes on the street or in the home of a friend or relative. However, there is considerable variation in how mistreatment of children is initially perceived, often influenced by the cultural background of the staff involved. In several instances, paraprofessional child-welfare workers in New York City overlooked what later was identified as serious physical abuse of children. In some agencies, a non-degreed counselor identifies abuse that is then "called in" by another staff member.

## CASE IN POINT

**Eliza Fell through the Cracks**

The mother of six-year-old Eliza Izquierdo was mentally ill with SUD. She believed her child was possessed by evil spirits. Eliza was kept home from school, neglected, and abused. She died from beatings in November of 1995. Warning signs had been missed or ignored by her school and her caseworker. Her death became a rallying point for social-service reform.

The Child Abuse and Protection Act also mandates confidentiality regarding specifics of child abuse cases, which has been frustrating to those seeking to eliminate negligence and neglect. Therefore, Congress amended the Act in 1992 to facilitate effective investigation and prevention of abuse.

In New York, the Social Services Law has interpreted in even more stringent terms, the stipulation of total secrecy. When child welfare authorities refused to testify in hearings on cases of severe child abuse that "fell through the cracks,"

legislators concluded that the state regulations functioned to protect bureaucratic incompetence or inaction. After verifying that federal regulators were in line with the 1996 regulations, New York enacted modifying legislation (Eliza's Law, see "Case in Point: Eliza Fell through the Cracks") to permit more disclosure for investigative purposes.

## Informed Consent

*Informed consent* means that the client has been educated as to the nature and form of disclosure. A client can give specific, written consent to the release of information. Every agency has a printed consent form that is explained carefully to every client (**FIGURE 2.1**). It is signed by the client

### Macedonia Memorial Medical Center Release of Confidential Information Consent Form

I, _____, a patient in the Addiction Services Unit at Macedonia Memorial Medical Center, hereby authorize the following disclosure of information from my treatment records/files:

I authorize Macedonia Memorial Medical Center to release information listed below to (name, title, organization to which disclosure is to be made):

_____

Purpose or need for disclosure (as specific as possible): _____

_____

Nature or extent of information to be disclosed (as limited as possible): _____

_____

This consent will terminate upon (date, event, or condition): _____

_____

I understand that my records are protected under federal regulations governing confidentiality of alcohol and drug abuse records, 42 CFR Part 2 and cannot be disclosed without my written authorisation unless otherwise provided for in the regulations. I also understand that information disclosed in the party listed above may not be disclosed to a third party without a separate signed consent, and that I may revoke this consent at any time except as legally proscribed.

Signature of Patient: _____

Signature: _____ Parent _____ Guardian _____ Authorized Representative

_____

Signature of staff person: _____

Date: _____

**FIGURE 2.1** Sample Consent form.

and by the individual performing the intake procedure and dated. The intake procedure, or the paperwork involved, may be implemented by a SUD counselor or a specialized intake worker. Blanket consent to release any or all information, or from or to any party, is acceptable in the Code of Federal Regulations (CFR). Written consent specifies the type of information that may be released, who is to release it and to whom, and for what purpose. It should include a statement that consent can be withdrawn. A client can usually withdraw consent verbally as well as in writing, although the time frame within which this occurs varies from state to state. The release must be signed and dated.

Confidentiality is not limited to the time of treatment. It starts when the client applies or calls to apply, even if he or she does not make an appointment. Confidentiality responsibilities do not end when the client exits treatment, whether from completion, recurrence, administrative discharge, or other circumstance, or if the client dies. The counselor and other staff must ensure that records are kept in such a manner that confidentiality will be preserved. The disposal of records presents the same expectation. "Dead" files cannot, for example, be taken in cartons to the street or left in unlocked cabinets in a storage room (ACA, 2014, B6.h). They must be shredded or incinerated.

## Disclosure and Redisclosure

Release of information with a client's informed consent binds the party to whom it is released not to release it to a third party (**FIGURE 2.2**). The information is bound by the confidentiality guidelines. Information disclosed by consent should be limited to that needed for case management, diagnosis, referral, and rehabilitation, and to process insurance claims or aid in the disposition of criminal proceedings.

The fact that clients are in treatment at a particular agency cannot be revealed without written consent of the client or a court order, regardless of who is inquiring. Relatives cannot simply call to speak with a client or ask if the client has arrived. Nor can staff always trust that a caller is who he or she claims to be.

> This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute the patient.

**FIGURE 2.2** Prohibition of redisclosure.

### CASE IN POINT

#### I Can't Give You That Information

One of the authors called a large treatment facility to inform a staff member of a scholarship award. The man who answered the phone gave a detailed and helpful account of the counselor's activities and how best to contact her. When he was asked, "Whom am I speaking with?" he responded, "I'm sorry, I can't give you that information, I'm a client."

Even when a counselor or other professional refers a client to treatment, once the client has completed intake at the treatment agency, staff members are following correct practice if they no longer communicate information about that client to the referring party, unless the client has given consent for release of information.

## Legally Incompetent Clients

If the client is incapable of understanding his or her rights and responsibilities, that client might be judged legally incompetent. Special consent

provisions are made for legally incompetent people and for minors; a legal guardian signs (or refuses to sign) consent form(s) [Figure 2.1]. In the case of releasing information about a deceased client, consent forms are signed by the person who has the power of attorney. A medical diagnosis does not constitute legal incompetency: It is only a piece of the evidence presented in courtroom procedures to determine a person's "competency." It is the responsibility of the agency's administration to ensure that privileged information is not released unless appropriate forms have been presented to document such legal determination, according to federal and state statutes.

## Clinical Discussion

Confidential information can be discussed for clinical and supervisory purposes. If such agency functions took place only in a strict chain of command, this would be quite clear. However, peer supervision, case conferences, and shift reports multiply the number of people who have access to confidential information. These factors, as well as the informal organization of the profession, make it difficult to define appropriate boundaries of secrecy. A baseline principle should be established that disclosure is on a need-to-know basis, as opposed to freely exchanging information with any and all personnel. Sharing of information cannot occur outside of a treatment unit in a larger institutional setting. For example, a nurse in detox cannot tell her friends on the maternity floor about her hallucinating patient. In addition to people involved in the client's care, the people who deal with billing and other recordkeeping may legally receive limited confidential information.

A counselor or agency must establish clear guidelines for access to confidential records by secretarial workers and volunteers. If they must have access, they must fully understand and implement confidentiality guidelines. The CFRs apply to all support personnel, administrators, volunteers, interns, and so on.

### ACTIVITY 2.2 What's the right thing to do?

*Phil is a counselor in an intensive outpatient program where you work. He has been employed in the field for three years and has been in recovery for 6 years. You have been close to him for most of that time. A month ago, Phil's son was killed in an automobile accident. In his grief, Phil went out and got intoxicated. He immersed himself without delay in his recovery fellowship as well as in short-term bereavement counseling, and he has confided only to you about the situation. State regulations mandate that counselors have at least 2 years uninterrupted "clean time." Phil is very afraid that if the agency finds out about his relapse, he will lose his job.*

**Discuss:**

- ☐ How do you feel about this situation?
- ☐ What would you say to Phil?
- ☐ Can you consult someone about this to get advice on your position?
- ☐ What should or can you say to the agency administrators?
- ☐ When is withholding information a breach of honesty?
- ☐ If you fail to disclose Phil's relapse, do you think you'd lose your job?
- ☐ How can you reconcile, on one hand, the trust and confidence of a friend and, on the other, loyalty to the agency and safety of clients?
- ☐ What do you think would be the best thing to do for your friend?
- ☐ What would be the right thing to do? Does this conflict with what you think would be best for Phil?

## Court-Ordered Disclosure

According to a Substance Abuse and Mental Health Services Administration (SAMHSA) publication on confidentiality (Lopez, 2002, 5),

> A federal, state and local court may authorize a program to make a disclosure of confidential patient identifying information. A court may issue such an order, however, only after following certain procedures and making certain determinations specified in the regulations. A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not sufficient by itself to require or even permit a program to make such a disclosure.

It further states that the court must give notice in writing with an opportunity to respond (unless it is prosecuting a patient). It must use a fictitious name in the process. It must have a "good cause" and cannot proceed if there is another source of the information. The information must be limited to the purpose of the order. Obviously, situations such as these must be handled through an attorney retained by the agency, who communicates only with the agency director or legal specialist. Earlier in this chapter, we described the changing rules on "evidentiary privilege," as pertaining to AA/NA and the Paul Cox case.

## Emergencies

Medical information usually shielded by confidentiality regulations may be released when necessary for evaluation and treatment of a medical emergency. For example, a diabetic woman may lose consciousness if her blood sugar is too high or too low. Her diabetic status must be communicated without hesitation if the client has such an emergency. Another example is that of a man having great difficulty breathing or appearing to have some sort of heart attack. A counselor is obligated to inform paramedics or other medical personnel about the medications the man takes (**FIGURE 2.3**).

## Statistical Aggregates

Information may be provided for statistical aggregates for research or audits, such as the percentage of clients who are entering treatment for the first, second, or third time (Figure 2.3). In releasing confidential information for these purposes, clients' names and other information that could identify clients cannot be released.

## Qualified Service Organizations

The services of outside agencies, such as laboratories and accounting firms, are often required. Such agencies, known as *qualified service organizations*, receive information that is necessary to perform their contracted functions. They are governed by a signed Qualified Service Organization Agreement (QSOA), under which they agree to abide by federal and local regulations concerning confidentiality.

### ACTIVITY 2.3 Should I tell?

*Your 28-year-old male client was married but engaged in anonymous sexual encounters with men. His family and in-laws were very anti-gay. He contracted a sexually transmitted disease, and discontinued treatment. Then you read in the newspaper that he committed suicide. His grief-stricken father called you, requesting any information you have that would help the family understand why his son killed himself. They speculate over what they did or did not do that was responsible for his death. Your memories and notes clearly show that his suicide was related to factors over which they had no control. What do you do? Because the client is no longer alive, can it hurt to share information with the family?*

**DISCUSS:**

- ☐ How should you respond to this family's wishes?
- ☐ Do you have an ethical responsibility to your client's family?
- ☐ Do you have to maintain this client's confidentiality even though he is dead? After all, you have information that would definitely lighten their grief.
- ☐ If the police investigate this unnatural death, what would you contribute to their fact finding?

ESSEX COUNTY COLLEGE STUDENT AFFAIRS AREA
Health Services Department
Office of the Substance Abuse Coordinator
877-3129

THIS PROGRAM IS REQUIRED TO COMMUNICATE TO EACH CLIENT THAT FEDERAL LAW AND REGULATIONS PROTECT THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS. A SUMMARY OF THE LAW AND REGULATIONS MUST BE GIVEN TO EACH CLIENT.

YOUR SUMMARY OF THE LAW IS PROVIDED BELOW.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a person attends the program, or disclose any information identifying a client as an alcohol or drug abuser *unless*

1. the client consents in writing.
2. the disclosure is allowed by a court order, or
3. the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client, either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290 dd-3 and 42 U.S.C. 290 ee-3 for federal laws and 42 CFR Part 2 for federal regulations.)

I HAVE RECEIVED A COPY OF THE ABOVE SUMMARY.

_____

(Client's signature)

Date:_____

**FIGURE 2.3** Exceptions to Confidentiality Rules.
Courtesy of Victor B. Stolberg, MA, EdM.

## Training

In situations in which case information or material is used for training counselors, the identity of the client must be disguised. Individuals who participate in such training must be informed of the need to maintain confidentiality. Unfortunately, participants in training who work at a local agency occasionally recognize a client and accidentally divulge either the name or information that provides a substantial hint to the client's identity.

### Pending Legislation

Counselors should be aware that specific state regulations that apply to minors, school-based programs, and other institutional settings might differ from those in effect for treatment agencies. These vary considerably from state to state, and litigation is pending concerning the role of parental consent and information that is provided to parents.

Finally, there is also considerable debate, as well as pending litigation, regarding the access of client information by managed-care entities. Many believe there already has been considerable rapid erosion of confidentiality by managed-care audits (Lewin, 1996; Scarf, 1996), which has resulted in harm to clients and decline of trust regarding the privacy of the client–counselor relationship.

### ACTIVITY 2.4 Wearing two hats

*Two hats is a term for an individual who has dual roles. Employees of SUD agencies often talk about two-hat problems to denote the staffer who is in a recovery fellowship with clients.*

Don is a person recovering from SUD who works at Reality Lodge, a large long-term treatment program staffed largely by graduates of this therapeutic community. He attends NA to maintain and strengthen his own recovery from addiction. At one meeting, a young woman named Cheryl makes a comment after the main speaker, in which she shares the difficulty she is having in staying drug-free. Cheryl happens to be a court-mandated client at the outpatient department of Reality Lodge, and Don knows that she has not shared these minor recurrences with the staff.

As an NA member, Don would never carry that information outside of the meeting, but as a counselor, he would notify his agency and then the court. Which hat decides what he does?

**Discuss:**

- ☐ What if Don calls the client on this and urges her to come clean herself? What if Cheryl tells him to mind his own business and warns Don not to break the confidentiality of NA?
- ☐ Should Don tell the agency staff what he heard at the NA meeting regarding this client's lack of sobriety? In weighing the anonymity of NA and the confidentiality of Don's agency, which carries more weight? What information can he share legally?
- ☐ What federal or state (use your state) regulations are relevant to Don's decision?
- ☐ Can you write a guideline for this type of situation to state clearly the agency's obligations? Shouldn't the agency tell counselors to leave a meeting where a client is present?
- ☐ What, if anything, should Don say to Cheryl?
- ☐ If Don remains silent, what are the implications for his interactions and relationships with his own supervisor and Cheryl's counselor?

## FINANCIAL ETHICS

In a national survey of "ethically troubling incidents" among psychologists, confidentiality-related problems were the largest category, followed by blurred, dual, or conflicting relationships. The category we are about to consider, the financial realm, ranked third (Pope & Vetter, 1992).

Commissions or rebates (*kickbacks*) for referrals and fee-splitting are unethical and illegal. It is inappropriate for a counselor to seek or accept private fee arrangements with a client who is working with his or her agency. A counselor may not treat a client in an agency-run group and then see him or her "on the side" for a fee; nor can a counselor who has a position with an agency list that position on a brochure or print it in other literature (business card, stationery) to recruit clients to a private practice.

A counselor may not use client contacts to promote a personal commercial enterprise or that of a relative or friend. For example, a counselor who learns that his client needs a good lawyer cannot refer that client to his sister the attorney, even with

all the goodwill and honesty possible. Furthermore, a counselor cannot help out her senior citizen client who has plumbing problems by getting him a good deal with her uncle in the septic tank business.

Borrowing money from a past or present client is a form of financial exploitation by the counselor who is using his or her position of power. It is unethical to accept gifts or tips from clients or their families (NAADAC, 2016, 1-40). For example, a counselor, even in a gesture of generosity, cannot lend money to a pregnant client for a taxi ride so she does not have to struggle with public transportation to get home. Furthermore, a counselor, while knowing the therapeutic value of a client's giving, cannot accept tickets to the ball game.

A counselor or other staff member should not regularly obtain meals from an agency's commissary designed for clients' meals, unless this is considered a convenience of employment, stipulated by contract or bylaw, or at least approved by the governing board or other legal authority.

Regrettably, each of these practices occurs in the treatment community, usually involving some combination of (1) lack of clarity on the part of the treatment agency regarding ethical guidelines, (2) personal or recovery relationships between worker and administrators, leading to enabling of these behaviors, and (3) premature counseling role for an individual in early recovery. Such individuals may have unsolved problems, such as compulsive gambling, overidentification with clients that leads to blurring of boundaries, overextension and burnout, or a need to compensate for low self-esteem by grandiose or narcissistic posturing.

Other financially unethical practices include the following:

- Data manipulated to indicate that more services are provided (such as calls of inquiry logged in as complete referrals) to justify continued funding levels or to boost reimbursement.
- In fundraising, concealing the actual use of funds for administrative purposes rather than for direct services, or concealing fees or percentage paid to fundraisers or to consultants who helped write a grant.
- In fundraising, portraying a "crisis" that threatens the existence of the agency and the loss of services to the deserving clientele.
- Solicitation of funds from former clients or client families who are subordinate in the power relationship and who are vulnerable and grateful. This can also lead to breach of confidentiality.
- In grant or other fiscal reporting, concealing use of funds for administrative purposes or for purposes that benefit administrative personnel, such as meals and travel not necessary for the operation of the facility.

## The "Checkbook" Diagnosis

Counselors may recognize that a client needs treatment, yet policy guidelines or gatekeepers of their medical coverage exclude all but the most severely afflicted. Agencies may be tempted to provide a billable or *checkbook* diagnosis. This phenomenon, also called *diagnostic creep*, can be motivated by a desire to provide help for suffering individuals or by the wish to fill available beds and keep reimbursement flowing to the agency coffers. The alternative is to deny care, refer elsewhere, or prematurely discharge clients whose problems are so severe that they might drain agency resources while bringing little reimbursement. Agencies that receive governmental support are often required by state regulations to set aside a certain proportion of treatment slots for "uncompensated care" or "charity care," that is, treatment of clients who have no medical coverage. Providing something other than an objective and proper diagnosis is unethical and, if egregiously inaccurate, could make an agency vulnerable to fraud.

A related practice to diagnostic creep is to use an adolescent SUD unit as a comprehensive unit for adolescents with problems, such as giving chemical dependency diagnoses to one-time LSD users or others without sufficient data. This is an unethical business practice. In addition, labels take on a life of their own: It is unfair, stigmatizing, and self-fulfilling to call adolescent drug experimentation a SUD.

This is but one example of *diagnostic slamming*, making the clients' diagnosis more severe or assessing the level of severity as more severe, in order to retain clients or garner a longer length of stay from third-party payers (White & Popovits 2004, 137–138).

## REPRESENTATION OF SERVICES

Claims made for the helping process in general and for the process in SUD counseling in particular must be realistic. People with SUD range from the vulnerable to the desperate, who have completely "hit bottom," or, at the very least, to those who live in chaos, disarray, and unhappiness. Counseling must not be presented as a miracle-working process or cash in on popular but unverified methods. It should not make claims other than the modest and realistic, SUD-specific, facilitation of recovery. A counselor or an agency should pay careful attention to how it represents itself, the services it offers, and the professional qualifications of employees.

Clients and prospective clients must understand the scope of treatment—what is and is not treated—methods of treatment, length and cost of treatment, and limitations of treatment. The client must be informed fully at the onset of counseling—if not before—about the purposes, goals, techniques, and procedures involved (ACA, 2014, A2b). The SUD counselor's core function of orientation is, then, prompted by an ethical standard. One corollary of this principle is that the client cannot be unknowingly or involuntarily the subject of any type of experiment (ACA, 2014, G2a,c).

Neither SUD counselors nor agencies should claim or imply treatment for nonsubstance use psychiatric disorders, related areas such as reduction of stress and anxiety, or solutions to problems of living. However, recurrence prevention may draw upon techniques used in psychotherapies, such as relaxation methods or assertiveness training, for the specific purpose of reducing the risk of recurrence (ACA, 2014, C4a).

Any representation of service must not engage in grandiose impression management that suggests, implicitly or explicitly, charismatic or other special qualities of the counselor. Testimonials from satisfied customers are, in general, ethically inappropriate, as they are selectively chosen and exploit a grateful client and/or unduly influence them from a position of power and authority (ACA, 2014, C3b).

Claims made of counselors' credentials should be specific and not misleading or inflated (NAADAC, 2016, III 9,III 12). The basis for use of terms, such as *clinician, therapist, certified*, and *licensed* must be clear. Some states have a tiered system that recognizes a minimal level of preparedness for the entry-level employee or SUD screening worker in a general social services setting as well as a professional counselor certification. It is unethical to represent the minimal credential as a board certification.

In-house job titles that are abbreviated after names (e.g., "John Smith, S.A.C." for an in-house title of Substance Abuse Counselor) must not be printed on agency stationery or business cards to imply certification or licensure. Some unethical misrepresentations include individuals employed in roles other than counseling at an agency who state or imply that they are counselors; volunteers who imply that they are staff; aide positions that are represented as full counseling positions; and counseling roles that are represented as administrative (NAADAC, 2016, III 9, III12).

An "official seal" of 12-step fellowship should not be claimed to attract clients. An agency should never give the impression that it is an "AA agency," or that many staff members are AA members. Alcoholics Anonymous would be the very first to object to this! Twelve-step fellowships neither recommend nor endorse agencies or organizations. Neither should a personal membership in fellowships be used to enhance recruitment. Not only is this practice unethical but it leads to confusion about the roles of fellowship peers, sponsors, and counselors.

With the managed-care system, treatment options have come under severe limitations. Some managed-care entities have discouraged or even forbidden healthcare providers from speaking freely with patients about their treatment options.

Providers feel that such "gag rules" put blinders on patients, preventing them from intelligently participating in decisions that affect their lives and contradicting the principle of informed consent. For physician providers, it may even violate the Hippocratic Oath, which states, "First, do no harm." Restraining rules on providers are being challenged in litigation in several states.

### Unethical Marketing of Services

This includes advertising any kind of specialized care where little is actually present. Examples include a general care unit that is promulgated as having a special women's program or a cocaine abuse program; patients being admitted to a "detoxification program," which is actually a general medical floor of a hospital with one part-time alcoholism counselor, if that, or even a "scatterbed" system whereby chemically-dependent clients are put wherever in the hospital there is an open slot. The point is not that even a "scatterbed" system would be preferable to no treatment at all, but that it is false advertising.

Online (digital) marketing schemes include unethical search engine optimization practices:

- **a.** toll-free numbers that pose as "helplines" and/or offer "free assessments," then tell all callers that they have SUD and refer them to their own programs or to those that have paid to be a designated agency.
- **b.** Related to the previously mentioned practice, ignoring the level of severity that should prompt the appropriate referral to level of care.
- **c.** Using a recognized agency name, but listing a phone number for another agency, thus "pirating" from another agency. A variant of this practice is to automatically redirect a computer from the recognized agency website or weblink to another, sometimes known as "clickbait."
- **d.** Claiming to exist in a state where they do not, or in a region of a state where they have no presence. A search using a well-known directory of practitioners for particular specialties, desiring providers in Berkshire County, MA, on the New York border, turned up clinicians, fine in their own right, but all in the Boston area on the other side of the state. This is perhaps a gray area of search engine malfeasance, but it is not of help to people in need.

## COMPETENCE

One of the key functions of ethical standards is to ensure that those entrusted to help are indeed reasonably ready and able to do so. Competency issues include counselor impairment, issues that cloud objectivity or distract from focus on the client's interest, and preparedness in a variety of knowledge and skill areas.

### Impairment

Counselors are impaired if they suffer from conditions that cause measurable declines in clinical performance or that compromise their counseling status. These include various psychiatric and neurologic conditions that render the counselor less than competent to perform counseling functions, as well as possible recurrence of substance abuse. NAADAC Principle III 41(2016) states that professional impairment needs appropriate treatment, and the SUD counselor certification boards in many states stipulate that recovering counselors must abstain from addictive substances. In many states, recurrences must be reported to the certification board and a 2-year suspension imposed.

### Lack of Preparedness

Lack of or inadequate training is a form of incompetence that jeopardizes the client's recovery. To put it even more strongly, because SUDs are chronic, progressive, often-fatal diseases, the incompetence of treatment staff can threaten the

lives of clients. Various incompetent actions, such as "improper treatment, inadequate treatment, negligence in use of technique, inadequate diagnosis" (Hogan, 1978), are the basis of many malpractice suits. However, competencies of SUD counselors have been a gray area up to this point. The definition of adequate preparedness has varied from state to state and from agency to agency. By the late 1990s, unified models of SUD counselor competency were becoming standard, as seen in the federally sponsored and published document, "Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice" (CSAT, 2006), which has been endorsed by the major SUD counseling constituencies.

It is natural for grateful, recovering persons to wish to assume a counseling role and give back to the community what they have gained. In fact, the SUD field was founded and developed by people recovering from SUD in a self-help milieu, whose commitment, energy, and skills at engaging and motivating people with SUD are often the envy of "straight" staff. The certification process was not linked initially to professional training, such as that required in nursing, social work, or psychology. The competence of nonprofessional or paraprofessional recovering counselors has been a great debate in the SUD field for over 40 years (Krystal & Moore, 1963; Lemere et al., 1964). However, few would claim now that personal recovery alone is sufficient preparation for the counseling role. Bissell and Royce (1994, 4) quote a halfway house director as saying, "Just because you had your appendix out doesn't qualify you to take out mine!" A majority of SUD counselors now have a bachelor's degree.

The SUD counselor without a degree faces disadvantages in completing paperwork, writing case presentations, and dealing with the certification process—topics that are taught in educational programs that lead to degrees. There are also questions regarding service to clients. SUD counselors who have had no training in screening concurrent psychiatric diagnoses are increasingly rare, and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) diagnoses are included in the classroom hour requirements in many states. In the past, bipolar (manic–depressive) clients were occasionally mislabeled as *dry drunks* (a term used in the recovery milieu to denote the disorganization, impulsivity, and mood swings that may be the aftereffects or consequences of long-term SUD). In 1990, a college intern who had acquired basic knowledge of psychiatric symptoms from his coursework observed a sober client seemingly in the throes of a manic state. His suggestion that a psychiatric consultation be obtained was rebuffed initially by inexperienced staff. He prevailed by petitioning the agency director; the consultation did confirm his suspicion of a mood disorder (Myers, 1991). Failure to refer clients appropriately keeps them from proper treatment and jeopardizes their safety and their lives.

On the other hand, SUD counselors bitterly note that other healthcare providers, including supervisory medical personnel, often sorely lack firsthand knowledge of SUD, miss the diagnosis, and cannot see through denial and deception. In 1988, at a public hospital in Brooklyn, New York, new graduates of foreign medical schools routinely overdiagnosed paranoid schizophrenia among people with SUD in an inpatient psychiatric unit.

The responsibility for ensuring staff competency lies primarily with the agency. Some agency administrators are happy to use untrained, newly recovering individuals, sometimes graduates of their own programs. Their motives usually combine elements of naïveté and the opportunistic use of a cheap labor pool (Bissell & Royce, 1994, pp. 5–6). To start their career, many people might be glad to be so "exploited." Some argue that such hiring practices are not necessarily unethical, if the employer offers or requires a systematic and mandatory program of continuing education, professional growth, and certification. Unfortunately, such programs have often been absent. Hiring untrained individuals generates unsophisticated, clinically limited "hothouse plants" who cannot function occupationally outside of a certain type of recovery program, can hardly differentiate themselves from clients, are prone to ethical compromises or burnout, and have limited writing skills and unsophisticated clinical skills.

### Lack of Responsibility

Irresponsible or careless behavior is incompetent and unethical. For example, a counselor's chronic lateness results in inadequate services, impairs the counseling relationship, and sets a bad example to people who are emerging from the personal chaos of SUD. Poor recordkeeping, frequent interruptions of sessions to take phone calls, and failure to follow up in case management are ineffective and disrespectful practices that constitute unethical treatment.

It is no shame to recognize the limits of competence. A counselor may be very good at what he or she does but should not feel impelled to tackle every skill area. The ability to identify one's limits of competency, as well as goals for further growth and training, is a clinical and ethical imperative, usually requiring some guidance and input from clinical supervisors. Not everyone can repair computers or perform brain surgery; why should any counselor who has not been trained as a family therapist feel compelled to assume the role of marriage counselor? Getting drawn into acting in areas outside of the scope of one's competency compromises ethical standards. Again, this can also harm clients and make the agency liable to lawsuits (ACA, 2014, C2a,b).

Many guidelines (NAADAC, 2004, Principle 8) consider it a duty to report incompetence to certification authorities. Private practices, agencies, and hospitals should have guidelines for dealing with incompetence.

## PROFESSIONAL GROWTH

Continued growth and ongoing education are tenets of ethics in most helping professions. No one would want a suicidal, bedridden, and biologically depressed relative treated by a psychiatrist who had never heard about Prozac, Zoloft, Paxil, or Effexor. Professional growth involves gaining the latest knowledge, strategies, and skills. It also means avoiding rote formulaic counseling, becoming out of date, and overburdening oneself. There are myriad ways of broadening competency and upgrading knowledge and skills:

- Read addictions treatment journals in your specialty, which might include *Alcoholism Treatment Quarterly*, *Journal of Child and Adolescent Chemical Dependency*, *Employee Assistance Quarterly, Schizophrenia Bulletin*, and so on.
- Attend professional seminars. It is usually best to avoid the expensive lecture circuits and cruises for continuing education unit (CEU) credits that are advertised with glossy brochures and vague inspirational themes, such as "Codependency in the Twenty-First Century"
- Attend agency networking events. Provider networks exist in many states or regions of states, but nonsupervisory staff are often unaware of their existence or are hesitant about asking to attend
- Be active in the Association for Addiction Professionals (NAADAC), which has affiliate organizations in most states, and attend their regional and national conferences
- Complete coursework in a SUD studies curriculum or in criminal justice or mental health curricula pertaining to special populations, such as addicted offenders and mentally ill chemical abusers
- Judiciously peruse Internet resources, including those of the Center for Substance Abuse Treatment (SAMHSA), National Clearinghouse on Alcohol and Drug Information (NCADI), and the Web resources on this text's website

For professional growth, the areas of knowledge that counselors should pursue include the following:

- Biomedical knowledge and practice regarding mentally ill chemical abusers
- Multicultural awareness and sensitivity. The DSM-5 addresses cultural sensitivity, both in diagnostic considerations for many long-recognized disorders as well as in a special appendix of culture-bound disorders.

The American Psychological Association as well as the Addiction Counselor Competency document (CSAT, 2006) consider cultural competency an ethical necessity.

- New medications, such as antipsychotics, antidepressants, and drug antagonists, along with their therapeutic possibilities and side effects. Counselors also need to keep abreast of over-the-counter medications that people with SUD use to supplement or substitute for street drugs, including legal stimulants contained in appetite suppressants and decongestants and "herbal" or "natural" energy boosters.
- New laws and regulations concerning confidentiality, liability, professional duties, insurance, and emergency treatment. SUD staff can be effective advocates for constructive legislation that favors equal standing for substance abuse and mental healthcare. Counselors should be aware of their professional association's stance on and analysis of upcoming legislation so they can be resources for information on how to vote on these important issues.
- Changes in the field, such as the decline in inpatient rehabilitation in favor of intensive outpatient treatment, and new screening and assessment tools, such as the Addiction Severity Index, American Society of Addiction Medicine Patient Placement Criteria, and others. Other developments in the field include the rise of recovery community organizations, and diversion into treatment by police through the LEAD and PAARI (Law Enforcement Addiction Diversion and Police Assisted Addiction and Recovery Initiative) models.

## COLLABORATION

As treatment models now emphasize collaboration with clients throughout the treatment process, this has been included in newer versions of ethical standards. A good example is that now, the treatment plan is drawn up collaboratively with the client (NAADAC, 2014, 1–14).

## NONDISCRIMINATION

Service cannot be denied to eligible clients because of their gender, race, ethnicity, nationality, sexual orientation, age, or physical characteristics. Neither can the quantity or quality of services vary according to any of these client characteristics. Note the word *eligible*. It is not discriminatory for an agency specializing in the treatment of pregnant women with SUD to refuse to treat a male, nor is it discriminatory for an agency to refuse to treat a child, where such specialized care is not within the scope of services provided by the agency.

Taking this a step further, some ethics guidelines state that a tendency to decline cases based on counselor bias and aversion to or anxiety about certain client types constitutes discrimination. Certainly, indigent, homeless, and mentally ill chemical abusers tend to suffer from discrimination, which creates an army of unwanted clients and people who are not getting the help they need. There is a lack of training for health professionals in SUD intervention and referral skills; confrontation and intervention take more time and energy for these types of clients than may be available to the professional with a large caseload. An old expression among physicians and nurses concerned with alcohol use disorder is the *ash can syndrome*, an ironic reference to a derelict who was discovered in the back (where coal ashes were kept in trash cans) and was subsequently treated for a host of ills directly or indirectly related to alcohol use disorder but never the alcohol use disorder itself. Another expression for the undesirable or demented client is the *GOMER* ("Get Out of My Emergency Room").

Statutes of many states require agencies to accept and treat a number of indigent (nonpaying or charity care) clients. In such cases, it is discriminatory to set up a covert system whereby a referring agent must refer a certain number of paying clients for every nonpaying client.

Using the same logic, a caseload skewed toward types of clients from which the counselor derives

the most personal satisfaction, or with whom he or she is most at ease, discriminates against others not in this category. This does not exclude an agency from assigning a counselor to work with a special population because he or she has the knowledge and skills required. For example, a Creole-speaking counselor may have a caseload primarily of Haitians.

It has become accepted among most helping professions that discrimination and incompetence exist if a particular cultural or ethnic group is not being served because counselors lack cultural competency skills.

## OBJECTIVITY

There is an incredibly wide range of opinion, theory, and belief in the SUD field, perhaps greater than in the treatment of nonaddictive disorders. The definition of SUD, beliefs as to the origin and course of SUD, and opinions as to how recovery is to be achieved inevitably vary among counselors and between counselor and client. While counselors need not hide their views, the counseling role is not to preach, lecture, convince, argue a position, or disparage the position of clients or other staff. Any of these stances disrespects the rights of others and certainly deflects from the counseling process. This is another gray area because, as Rhodes (1992, 43) remarks, clients may want help and guidance in an ethical exploration of their issues. The undersocialized client needs habilitation, and the sociopath requires treatment that includes development of a value system. A skilled, objective counselor can facilitate value clarification and development of an ethical system with clients without imposing his or her belief system or disparaging that of others.

### **ACTIVITY 2.5** Can't handle that God stuff

*Marcia, who comes from a Hasidic Jewish family and rebelled to marry a secular Jewish man, enters treatment under family pressure. She goes to a few AA meetings at the urging of her counselor but feels she is being forced to go along with something she considers similar to her "repressive" family environment. "Another dogmatic in-group who only talk to themselves," is the way she puts it. She strongly declares her desire to recover from her alcoholism but does not want to be forced to go along with "the God thing."*

**Discuss:**

- ☐ How would you approach Marcia?
- ☐ Are these religious issues or family issues?
- ☐ Would you address her issues about religion in a treatment plan? If so, how?
- ☐ Would forcing Marcia to attend AA meetings or denying her treatment be religious discrimination?
- ☐ Do you know anything about Hasidism?
- ☐ Would you need to know about Hasidism? Her family?
- ☐ Would it be ethical or appropriate to refer Marcia to another program or agency?

## AN ETHICAL TREATMENT SYSTEM

It is important to identify systemic factors in ethical choices. The web of systemic influences (economic and regulatory systems, agency and societal cultures) reaches down to surround client and counselor, determining how policies and procedures are implemented in day-to-day counseling practice. An example is the screening function, which is supposedly an objective determination of appropriateness and eligibility for admission, but, which distorted by market competition and managed-care constraints, stretches or even invents a diagnosis for mercenary or altruistic reasons. A more complex example is the apparent fact that a client cannot make sufficient progress in a particular setting. It is the ethical responsibility

of the counselor and agency to terminate and/or transfer the client and be knowledgeable about resources (ACA, 2014, A11a,b,c,d). Or, within an agency, if a particular counselor is a bad match for the client, the client should be reassigned. All too often, however, clients are retained inappropriately. This situation may be caused by systemic factors, such as the need to maintain client statistics as well as countertransference issues, such as anxiety about appearing to be a failure, overinvolvement, and the need to play a rescuer role. Obviously, a great deal of honest, critical thinking is required to determine all the elements of influence. A climate of secrecy and denial, antithetical to a therapeutic environment, makes it unlikely that accurate assessment of agency practice or personal and professional growth will take place.

## UNETHICAL PRACTICES IN POST-TREATMENT HOUSING

Periodically, there are exposés and scandals involving dubious halfway houses. Most recently, it was reported that a chain of so-called "three quarter way houses" received commissions from outpatient programs that residents were told to attend. Worse, in order to stay domiciled, the administration of this chain forced residents to drink or take drugs in order to qualify for the outpatient programs that provided commissions (Barker, 2015a, b). The National Association of Recovery Residences has developed a code of ethical standards to help avert such situations (NARR, 2016).

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